Report of the JCST Phase 1 Review Group

A response from

ASiT
The Association of Surgeons in Training
www.asit.org

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Authors:

Mr Goldie Khera (President)
Mr James Milburn (Vice-President)
Mr Charlie Giddings (Immediate Past President)
Mr Edward Fitzgerald (Past President)

On behalf of the ASiT Executive and Council

35-43 Lincoln's Inn Fields
London, WC2A 3PE, UK
Tel: 0207 973 0301
Fax: 0207 430 9235
Web: www.asit.org
Email: info@asit.org

Registered Charity number: 274841

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1. Summary Response

1.1 ASiT welcomes the phase 1 review of the JCST and its overview of the current roles of surgical training bodies.

1.2 We support measures to improve the JCST's profile amongst trainees although this must be accompanied by clarity regarding its mandate, remit, and responsibilities in surgical training, particularly with regard to areas that the Royal Surgical Colleges and GMC also have over-sight of.

1.3 ASiT agrees with the suggested integration of the trainee fee into Surgical Royal College subscriptions, although believe the fee needs to be further scrutinised for value and transparency given the rising cost of surgical training and rapidly increasing medical student debt.

1.4 We are concerned regarding future trainee input into the JCST committee and believe that ASiT is the only organisation that can represent all surgical trainees at core and higher surgical training levels across all nine surgical specialties.

1.5 Developments regarding the ISCP, SPACE data, future training surveys and measures to ensure the robustness of visits are awaited.

1.6 Given the lack of formal response by the JCST to the Eraut report, we hope that an education-specific review of the JCST will also be undertaken to focus on its' educational utility, particularly with regards to evidence for the increasing burden of workplace-based-assessments that it currently oversees through the ISCP.

1.7 We hope our response will be reviewed and our concerns addressed in phase 2 of the JCST review group analysis.

2. Introduction

2.1. The Association of Surgeons in Training welcomes the opportunity to respond to the JCST phase 1 review group report.

2.2. The Association of Surgeons is an educational charity supporting the professional development of surgeons in training. Our association represents UK trainees from all nine surgical specialities and is one of the largest professional groups with over 2,000 members.

2.3. The changes proposed in the English White Paper "*Equity and Excellence: Liberating the NHS*" and transition of PMETB under the auspices of the GMC has led to uncertainty over the purpose of training bodies, their respective roles and the regulation of surgical training.

2.4. Therefore, this JCST review is timely and of significant importance in the future debates surrounding surgical training in the UK.

2.5. ASiT representatives were interviewed as part of this phase 1 review and we are grateful for the opportunity to provide a trainee perspective.

2.6. We acknowledge this review process comprises 2 phases and phase 2 will subsequently review the responses to the findings and recommendations of the report with potential external involvement.

3. Comments on the Findings of the Trainee and Representative Bodies

3.1 The views expressed by ASiT during the interview process were generated from within the ASiT Council which includes regional and speciality representatives from throughout Great Britain and Northern Ireland. Our views reflected those in our ASiT position statement "*The Future of Surgical Training*", recent survey "*The cost of surgical training*" and recent response to "*Liberating the NHS: developing the healthcare workforce*".

3.2 We agree the views expressed therein are a fair reflection of the current concerns of surgical trainees regarding the JCST.

3.3 We are not surprised that trainees surveyed were confused about the function and need for a JCST; equating it with the ISCP, exam process or administration alone. We would support the JCST in improving its profile to its 'clients' the trainees – as a portal for this the ISCP website already exists.

3.4 We wish to re-emphasise that the cost of pursuing a surgical career continues to rise and the trainee fee needs further scrutiny as detailed in our recent statement "*The cost of surgical training".* We strongly believe that there should be a single fee and that separate College subscriptions are unacceptable.

4. Comments on other Stakeholders opinion

4.1 The BMA opinion on transferring the burden of the trainee fee to employers is of note. Announcements from the MEE and HEE regarding the allocation and size of training budgets are awaited and this notion may be worthy of open discussion.

4.2 The considered support by the BMA for trainees who failed an ARCP because they did not use the ISCP should serve as a strong reminder for the JCST of their legal remit in appropriating a trainee fee without exception for the progression of training.

4.3 The majority of deaneries suggesting the trainee fee should be further increased cannot be supported given recent reductions in study leave budgets and the escalating cost of surgical training and medical student debt coupled to the suspension of salary increases.

4.4 The views of the NHS Employers and NHS Confederations are of serious concern. The assertion that "*adequate training could be delivered in 48 hour week*" is contentious and we await with interest the result of the UK government's recent application to the EU for this to be re-examined. Furthermore this seems at odds with their assertion that "*many trainees were not ready for consultant posts at the end of training*". This statement devalues the fact that a trainee currently attaining CCT has achieved more competencies and assessments under greater scrutiny than ever before. The NHS viewpoint should be backed by evidence as it risks devaluing and demoralising highly trained surgical trainees, their trainers and the current assessment process leading towards CCT. If true, then it suggests that the heavy burden of workplace-based-assessments introduced by the JCST through the ISCP are not contributing to training and their use should be re-considered.

4.5 We would welcome further clarification by the NHS Employers and Confederation on their suggestion of a "*period spent in a service post as part of training*". It is uncertain if this refers to pre- or post-CCT and how this may be incorporated into the current training structure. The balance between training and service has progressively edged towards service to ensure rota compliance and maintain out-of-hours cover. To ensure maximal educational opportunities are achieved within the 48-hour week it is imperative training be given a higher profile. ASiT views the attainment of CCT as evidence of competence for full consultant appointment and remains firmly against a proposed subconsultant grade.

4.6 It of great concern that the NHS Confederation should suggest that future surgeons may possess an autocratic manner and be poor team players. We ask for evidence to support this statement as this is based on little factual support. Trainee surgeons are selected and trained to work in the modern multi-skilled, team based NHS environment. We accept that if these behaviours persist in isolated pockets that it will blemish the otherwise highly professional reputation of the consultant body. However, these undesirable traits are surely the gross exception and we would therefore wish the NHS Confederation to reconsider this.

4.7 We note Department of Health "irritation" that some deaneries added a third core training year without national directive. ASiT strongly supports a third year of core surgical training. Additional experience, if gained in the right speciality mix, benefits training. A third year may influence the chances of attaining a specialty training post in some specialities, where 12 months experience is a condition of gaining a NTN. This may be to the detriment of those with <12 months experience who are unable to gain sufficient experience to progress. However, it is important that trainees do not feel forced into placements to ensure staffing levels rather than training needs. We urge a uniform approach to ensure equitable opportunities, with adoption of a third year of surgical training.

5. Comments on the Conclusions

5.1 We agree that the Colleges are in an excellent position to advise on surgical training and the JCST has a significant role to play in coordinating the intercollegiate stance. The JCST role needs to be clarified given the expanding stakeholders in surgical training with uncertainty over provider skills networks, MEE and HEE. This phase 1 review was unable to meet its terms of reference in this regard and we would urge timely review once this has been clarified.

5.2 The GMC, as the unified regulator of the profession, delegates duties to the JCST which is appropriate given the acknowledged expertise of the Colleges. As a representative body for all surgeons in training we would like current motivated surgeons to be leading future surgical training through the JCST as opposed to further delegation.

5.3 The comment regarding the developing relationship between the JCST, SACs, GMC, Deaneries and Schools is of importance, as trainees are often required to chart a course through these conflicting bodies. Refinement of surveys and visits must be commended to prevent unnecessary duplication and allow potential cost savings.

5.4 The statement "*There is much work to be done with trainees*" will resonate with each individual trainee. From complete ignorance of the existence of the JCST to frustration felt at its lack of utility or transparency, all trainees would benefit from improved future communication from the JCST.

5.5 The training fee provokes fierce criticism from trainees as it is felt to be unjust and another blow during a period of financial hardship. We agree the incorporation of the training fee into College subscriptions to be spread among all Members and Fellows may help quell growing disenchantment. However, obscuring a trainee fee does not address the

desire also for transparency as to where the funds are distributed. This key point vexes many and as suggested may lead to legal challenges to the necessity of ISCP payments to progress through training.

5.6 The sustained political campaign against the Royal Surgical Colleges to remove them from training and education has caused an unhealthy division from the very bodies designed to defend high quality patient care and surgical standards. The lamentable issue of the introduction of the fee to support the JCST may mean future consultants will not see the Royal Colleges as their organisations and choose not be members of the Royal Colleges: ASiT takes this very seriously.

5.7 The ISCP has experienced many criticisms and the position of ASiT will be expressed in a separate statement; particular concerns surround the heavy burden of workplace-based-assessments (e.g. DOPS, CEX, etc) that appear to be educationalist driven but with little appreciation of benefit by trainers and trainees alike.

5.8 A revitalisation of the role of GMC and JCST visits is essential. As specified, the inconsistencies in their remit and authority must be addressed. Trainees do not feel that the current system of inspection of posts is robust enough and the findings should be published to trainees to inform the future post holders.

5.9 ASiT has campaigned for the release of SPACE data, as this would permit an overview of UK training standards with multiple benefits. We as trainees invested time and effort into completing this comprehensive survey and the data received, however flawed, remains our data. We welcome the acknowledgement of trainee survey duplication and the development of a unified survey is a progressive step.

5.10 The first allegiance of surgeons is to their patients and not their profession. As previously commented, the accusation over lone surgeons working in a dictatorial manner is contentious but ASiT agrees the rare cases where these practices persist must be eradicated. ASiT fully supports recognition of the importance of team and multi-disciplinary working as part of the curriculum and it is rightly a key facet for a trainee surgeon and indeed any modern health professional.

5.11 The promotion of consultant mentoring as a formal arrangement is to be welcomed given the unofficial state and implementation it currently occupies.

5.12 The need for the availability of more flexible training was expressed by trainees, Deans and the NHS; ASiT would support this aspiration.

5.13 We agree that unregulated Post-CCT fellowships outside the control and funding of Deaneries are a potential area of concern, balanced against the excellent training opportunities that some offer for sub-specialty practice. ASiT will be publishing updated recommendations on this issue later in the year.

6. Comments on the Recommendations

6.1 ASiT broadly accepts the recommendations of the phase 1 review although with the following concerns.

6.2 We cannot support Recommendation 1 (Appendix 4 and Appendix 5) on the proposed constitution of the JCST and SACs. This suggests that "*Only one representative of ASiT* ***or*** *BOTA would be members of the committee".* ASiT is a pan-surgical educational charity incorporating all nine disciplines. The suggestion that BOTA alone may be invited to JCST meetings is of concern as they represent a single speciality. The ASiT Council has speciality representation from all trainee bodies representing all disciplines of surgery, with members training in all nine surgical specialties, and is therefore the only unified body representing all trainees at all stages of training. We suggest each SAC should incorporate a representative from their designated speciality trainee organisation in their respective constitution but for ASiT to remain solely on the JCST constitution.

6.3 ASiT's concerns regarding the ISCP and trainee fee referred to in recommendations 8 and 9 have been discussed and should be considered carefully. We support the trainee fee being incorporated into annual Royal Surgical College subscriptions.

6.4 We support and would like to be involved in the dissemination of information regarding the JCST to trainees. The ISCP website remains the logical method of communicating this.

7. References & Further Reading

7.1 ASiT has published a number of statements which are available at:

http://www.asit.org/resources/articles

7.2 These include the following related position statements:

- Cost of Surgical Training (April 2011)
  http://www.asit.org/news/costofsurgicaltraining
- Future of Surgical Training (August 2010)
  http://www.asit.org/resources/articles/future
- EWTD for Surgical Trainees (August 2009)
  http://www.asit.org/resources/articles/ewtd_for_surgical_trainees
- Optimising Working Hours to provide Quality in Training and Patient Safety (January 2009)
  http://www.asit.org/news/EWTD
- Post-CCT Non Consultant Grade (December 2008)
  http://www.asit.org/resources/articles/sub_consultant
- The Structure of Core Surgical Training (January 2008)
  http://www.asit.org/resources/articles/core-surgical-training

7.2 Previous ASiT responses to relevant reports include:

- Liberating the NHS: developing the healthcare workforce (May 2011)
- RCSEng Surgical Fellowship Scheme (February 2011)
  http://www.asit.org/news/surgicalfellowship
- Time for training – A review of the impact of the European Working Time Directive on the Quality of Training (December 2010)
  http://www.asit.org/news/asit_reponse_temple
- Medical Education England, Medical Programme Board Discussion Document: Core Surgical Training and Experience in Surgical Specialities in England (August 2010)
- The ISCP Evaluation Report by Professor Michael Eraut (April 2009)
  http://www.asit.org/news/eraut

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